How to file an application for adjudication of claim

Complete this form if you have a disagreement with your employer or its insurance company about your case and you want it resolved by your local Workers' Compensation Appeals Board (WCAB). Filing this form opens a case with the WCAB.

You can also complete this form if you think you may need the WCAB to resolve a dispute in the future and the time allowed for you to file the application could run out. If you have questions about whether time limits apply in your case, contact your local Information and Assistance office. The phone numbers are listed on the back of this guide.

Complete the form and follow the instructions on the back.

Please note that a hearing in your case will not be scheduled until a declaration of readiness to proceed is filed (see I&A guide 5).

The following papers must be included with your completed application:

1. A copy of your claim for workers' compensation benefits (required only for injuries that happened between 1-1-90 and 12-31-93). See I&A guide 1.

2. Declaration required by law (Labor Code section 4906 (g) -- see attached).

A proof of service is recommended. See attached.

Send the originals to your local WCAB office and a copy to the insurance company. Keep a copy for your records.

If you need help, call an Information and Assistance (I&A) office, or attend a workshop for injured workers. The local I&A phone numbers are listed on the back of this guide. You can get information on a local workshop from the I&A office or on the Web at www.dir.ca.gov/dwc.

I&A 4
Rev. 5/05

DIVISION OF WORKERS' COMPENSATION
DISTRICT OFFICES

ANAHEIM, 92801-1162
1661 N. Raymond Ave., Suite 202
Information & Assistance Unit (**714) 738-4038**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit (**661) 395-2514**

EUREKA, 95501-0481
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2280
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

GOLETA, 93117-3018
6755 Hollister Avenue, Suite 100
Information & Assistance Unit (**805) 968-4158**

GROVER BEACH, 93433-2261
1562 W. Grand Avenue
Information & Assistance Unit **(805) 481-3380**

LONG BEACH, 90802-4339
300 Oceangate Streets, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 West 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, CA 90292
4720 Lincoln Blvd. 2nd floor
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1402
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030
2220 East Gonzales Road, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91766-1601
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96001-2796
2115 Civic Center Drive, Suite 15
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit (**951) 782-4347**

SACRAMENTO, 95825-2403
2424 Arden Way, Suite 230
Information & Assistance Unit (**916) 263-2741**

SALINAS, 93906-2204
1880 North Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 West Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2170**

SAN FRANCISCO, 94102-7002
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1482
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SANTA ANA, 92701-4070
28 Civic Center Plaza, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA ROSA, 95404-4760
50 "D" Streets, Suite 420
Information & Assistance Unit (**707) 576-2452**

STOCKTON, 94202
31 East Channel Street, Suite 344
Information & Assistance Unit (**209) 948-7980**

VAN NUYS, 91401-3373
6150 Van Nuys Blvd., Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 05/07

SAMPLE

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. (Leave blank)

M Your name

Your complete home address
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No. Your social security number

(Leave blank)
(APPLICANT. IF OTHER THAN INJURED EMPLOYEE)

(Leave blank)
(APPLICANT'S ADDRESS AND ZIP CODE)

VS.

Company you were working for at time of injury
(EMPLOYER--STATE IF SELF INSURED)

Company's address
(EMPLOYER'S ADDRESS AND ZIP CODE)

Name of your company's insurance carrier
(EMPLOYER'S INSURANCE CARRIER OR, IF SELF INSURED, ADJUSTING AGENCY.)

Insurance carrier's address
(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born Your birth date (DATE OF BIRTH), while employed as a Your job title at time of injury (OCCUPATION AT THE TIME OF INJURY)

on date of accident (DATE OF INJURY) at Address where accident took place (ADDRESS) (CITY) (STATE) (ZIP CODE)
by the employer, sustained injury arising out of and in the course of employment to:
Parts of your body that were injured
(STATE WHICH PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: Indicate what you were doing at time of injury
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at the time of injury were: Your weekly or monthly salary and hours you work per week; include tips, meals, lodging
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
or other advantages
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: Indicate the last day you worked due to the injury
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid ____ (YES) ____ (NO) $ ____ (TOTAL PAID) $ ____ (WEEKLY RATE) Date of last payment from insurance carrier (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury ____ (YES) ____ (NO)

7. Medical treatment was received ____ (YES) ____ (NO) Date of last visit to the doctor (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ____ (YES) ____ (NO) Other treatment was provided paid by: Indicate if you or any other person or private insurance company paid for any of your treatment
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care related to this claim? ____ (YES) ____ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are Names of doctors or hospital not paid by insurance carrier
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: Other cases with the WCAB- write case numbers and injury dates
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity ____ Permanent disability indemnity ____ Reimbursement for medical expense ____ Medical treatment ____ Compensation at proper rate ____ Rehabilitation ____ Other (Specify) ____
AND APPLICANT REQUESTS A HEARING AND
AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at City (CITY), California Date (DATE)

(APPLICANT'S ATTORNEY)

Your signature
(APPLICANT'S SIGNATURE)

DWC/WCAB form 1

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS (DWC/WCAB Form 9) IS A PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendant(s) named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Workers' Compensation.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney fee will be set by the DWC at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

All blanks in the application shall be completed. Where the information is unknown, place "unknown" in the blank. If *medical treatment is paid for by Medi-Cal, Medicare, group health insurance or private carrier, please specify.*

Service of Documents

Your attorney or agent will serve all documents in accordance with Labor Code Section 5501 and Section 10500 of the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file a Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the office of the Workers' Compensation Appeals Board.

SAVE PRINT CLEAR

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR ADJUDICATION OF CLAIM
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. _____

M _____ _____
(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No. _____ _____

_____ _____
(APPLICANT. IF OTHER THAN INJURED EMPLOYEE) (APPLICANT'S ADDRESS AND ZIP CODE)
VS.

_____ _____
(EMPLOYER--STATE IF SELF INSURED) (EMPLOYER'S ADDRESS AND ZIP CODE)

_____ _____
(EMPLOYER'S INSURANCE CARRIER OR, IF SELF INSURED, ADJUSTING AGENCY.) (INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a _____ (OCCUPATION AT THE TIME OF INJURY)

on _____ (DATE OF INJURY) at _____ (ADDRESS) (CITY) (STATE) (ZIP CODE)
by the employer, sustained injury arising out of and in the course of employment to:

_____
(STATE WHICH PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: _____
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at the time of injury were: _____
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

_____
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: _____
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid ☐ (YES) ☐ (NO) $ _____ (TOTAL PAID) $ _____ (WEEKLY RATE) _____ (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury ☐ (YES) ☐ (NO)

7. Medical treatment was received ☐ (YES) ☐ (NO) _____ (DATE OF LAST TREATMENT) All treatment was furnished by the Employer or Insurance Company ☐ (YES) ☐ (NO) Other treatment was provided paid by: _____
_____ Did Medi-Cal pay for any health care
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)
related to this claim? ☐ (YES) ☐ (NO) doctors not provided or paid for by employer or insurance company who treated or examined for this injury are _____
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

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_____
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

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Permanent disability indemnity ☐ Reimbursement for medical expense ☐ Medical treatment ☐
Compensation at proper rate ☐ Rehabilitation ☐ Other (Specify) _____
AND APPLICANT REQUESTS A HEARING AND
_____
AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ (CITY), California _____ (DATE)

_____ _____
(APPLICANT'S ATTORNEY) (APPLICANT'S SIGNATURE)

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IMPORTANT!

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SAMPLE

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of *Your county* California. I am over the age of eighteen years, my (business/residence) address is:

Put your home address

On *today's date*, I served the attached *application for adjudication of claim* on the *your employer* in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at *city where you mailed this* addressed as follows _____

your employer's name and address here

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on

(date) *Today's Date*, at *City* California.

Type or print name *Type or print name*

Signature _____

PRINT CLEAR

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of _____ California. I am over the age of eighteen years, my (business/residence) address is:

_____

_____

On _____, I served the attached _____ on the _____ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at _____ addressed as follows _____

_____

_____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) _____, at _____ California.

Type or print name _____

Signature _____

PRINT CLEAR

DECLARATION PURSUANT TO LABOR CODE SECTION 4906(g)

Pursuant to Labor Code Section 4906(g), I declare under penalty of perjury that I have not violated Section 139.3 and I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Dated: _____

_____
Signature

Before signing this form, you should be aware that: “Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony.”